CHAMPVA POLICY MANUAL

CHAPTER 3
SECTION 4.1
TITLE: OTHER HEALTH INSURANCE (OHI)

AUTHORITY: 38 CFR 17.270(a)(b) and 17.277

RELATED AUTHORITY: 32 CFR 199.8

I. EFFECTIVE DATE(S)

A. October 1, 1987, for claims processed under the DRG-based inpatient payment system.

B. The OHI calculation was changed for Medicare-primary claims processed under the DRG-based inpatient payment system effective January 1, 1999.

II. DEFINITIONS

A. Other Health Insurance. Other health insurance is an insurance plan or program that is designed to provide compensation or coverage for expenses incurred by a beneficiary for medical services and supplies. It includes plans or programs for which the beneficiary pays a premium to an issuing agent as well as those plans or programs to which the beneficiary is entitled by law or as a result of employment or membership in, or association with, an organization or group or student insurance. An insurance plan provided to a beneficiary as a result of his or her status as a student (student insurance) is also included. Additionally, managed care plans that provide comprehensive services at discounted rates or a set co-payment depending on the type of service or supply provided are included. These plans include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Paid Prescription Plans.

B. Medical service or health plan. A medical service or health plan is any plan or program of an organized health care group, corporation, or other entity for the provision of health care to an individual from plan providers, both professional and institutional. It includes plans or programs for which the beneficiary pays a premium to an issuing agent as well as those plans or programs to which the beneficiary is entitled by law or as a result of employment or membership in, or association with, an organization or group.

III. POLICY

A. Existence of Other Health Insurance (OHI). Prior to payment of any claim for services or supplies rendered to a CHAMPVA beneficiary, it must be determined whether other coverage exists under any other insurance plan, medical service, or health plan.

1. Benefits will not be paid until the claim has been filed with the other health insurance and a payment determination issued (explanation of benefits) by the other insurer.

2. Except for Medicaid, CHAMPVA supplemental policies, and State Victims of Crime Compensation Programs, CHAMPVA is always the secondary payer of health care benefits.

B. Waiver of Benefits. Beneficiaries do not have the option of waiving benefits of another insurance plan or program in order to place CHAMPVA as the primary payer.

1. Reimbursement will not be made for services, which are available through an insurance carrier to its members, if for any reason the member obtains the services outside the insurance carrier's providers.

2. CHAMPVA will be the primary payer for any CHAMPVA-covered services that the insurance carrier certifies in writing that they would not have paid or covered even if the services had been obtained through their providers.

C. Last Pay Limitations.

1. When double coverage exists, the CHAMPVA payment will not exceed the amount that would have been paid in the absence of other coverage.

2. For all claims, except those subject to the DRG-based payment system, there is a three-step method to determine the CHAMPVA payment.

STEP	ACTION
1	Determine the allowable amount that would have been paid in the absence of other health insurance. This computation applies the beneficiary annual deductible (if applicable) and the cost share.
2	Subtract the OHI payment from the billed amount.
3	Compare steps 1 through 2 and pay the lower amount.

An example of this payment computation is outlined as follows. A provider bills $60.00 for a procedure; the OHI allowable amount is $60.00; the CHAMPVA allowable for this procedure is $58.00; and the OHI payment is $48.00. The full CHAMPVA deductible has been met.

Step 1
$58.00 (CHAMPVA allowable)
x .75 (multiply by 75% to determine the CHAMPVA cost share)
$43.50

Step 2
$ 60.00 (Billed amount)
- 48.00 (OHI payment)
$ 12.00

Step 3 Compare steps 1 and 2. CHAMPVA will pay the lesser amount or $12.00. In this case, the beneficiary will not have an out-of-pocket expense—the OHI paid $48.00 and CHAMPVA paid $12.00 so the provider received a total payment of $60.00.

2. For all inpatient claims subject to the DRG-based payment system, there is a five-step method to determine the CHAMPVA payment. For Medicare DRG-based OHI calculation, refer to Policy E.6.c.(2.).

STEP	ACTION
1	Determine the DRG-based amount CHAMPVA will allow minus the beneficiary's cost share.
2	Determine the DRG-based amount CHAMPVA will allow minus the OHI payment.
3	Subtract the OHI payment from the billed charge.
4	Subtract the cost share from the billed charge.
5	Compare the amounts in steps 1 through 4 and pay the lowest.

An example of this payment computation is outlined as follows. The billed charge for two days of inpatient care is $2,554.24. The claim is subject the DRG-based system and the DRG amount is $1,276.20. The cost share is $414.00. The OHI plan paid $2,454.24. The hospital submitted a claim for $2,554.24 along with the other insurer's explanation of benefits showing the billed amount had been partially paid.

Step 1
$1,276.20 (CHAMPVA allowed amount)
- 414.00 (Cost share)
$ 862.20

Step 2
$1,276.20 (CHAMPVA allowed amount)
-2,454.24 (OHI payment)
($1,178.04)

Step 3

$2,554.24 (Hospital's billed charge)
- 2,454.24 (OHI payment)
$ 100.00

Step 4

$2,554.24 (Hospital's billed charge)
- 414.00 (Cost share)
$2,140.24

Step 5 Compare steps 1, 2, 3, and 4. No CHAMPVA payment will be made as the lesser amount is Step 2, which shows a negative balance.

D. CHAMPVA and OHI Pharmacy Co-payments. CHAMPVA will reimburse the beneficiary's co-payment expenses for pharmacy prescriptions up to the CHAMPVA allowable.

E. CHAMPVA and Medicare.

1. When payment for covered services and supplies can be made under both Medicare and CHAMPVA, Medicare is the primary payer.

a. CHAMPVA is secondary to Medicare Parts A and B, Medicare HMOs, and Medicare supplemental policies.

b. For health care services covered under both plans, CHAMPVA will pay up to the CHAMPVA allowable amount for the actual out-of-pocket cost incurred by the beneficiary over the sum paid by Medicare.

2. Cost sharing, deductible, and annual catastrophic cap requirements are applicable.

3. For health care services payable only under one plan, and not both, beneficiaries are responsible for payment of the applicable Medicare or CHAMPVA cost share and deductible.

4. When Medicare denies a claim as not a benefit, i.e. prescription drugs, and the service is a CHAMPVA benefit, the claim will be processed with CHAMPVA as primary payer. However, if Medicare denies a claim based on a medical necessity determination, CHAMPVA also will not provide coverage.

5. When a Medicare benefit period is exhausted, CHAMPVA will be the primary payer during the period of exhaustion.

6. Medicare and Deductibles.

a. As there is no CHAMPVA inpatient deductible, in most cases the full Medicare inpatient deductible is covered by CHAMPVA.

b. For outpatient services, there is a CHAMPVA deductible for the beneficiary to meet however, in most cases, the amount CHAMPVA will pay after Medicare will cover the beneficiary's portion of the Medicare co-pay. The CHAMPVA payment will also cover a portion of the beneficiary's Medicare outpatient deductible. CHAMPVA will not pay the beneficiary's Medicare Part B premiums.

c. In most cases, the beneficiary will have no final out of pocket expense. However, there will be some circumstances in which the beneficiary will not be reimbursed the full out-of-pocket expense.

(1.) Outpatient services covered by Medicare and CHAMPVA: For example, a beneficiary is billed $60.00 for outpatient services. The Medicare allowable is $60.00. The CHAMPVA allowable is $58.00. The Medicare payment is $48.00 (which is 80% of their allowable of $60.00). The Medicare deductible was met, but the CHAMPVA deductible of $50.00 has not been met.

Step 1	$58.00	(CHAMPVA allowable amount)
	- 50.00	(CHAMPVA deductible)
	$ 8.00	
	x .75	(multiply by 75% to determine the CHAMPVA cost share)
	$ 6.00	
Step 2	$60.00	(Billed amount)
	- 48.00	(Medicare payment)
	$12.00	

Step 3 Compare Steps 1 and 2. CHAMPVA will pay the lesser of the two amounts, or $6.00. The out-of-pocket expense to the beneficiary is $4.00—the beneficiary is liable up to the CHAMPVA allowable amount of $58.00. OHI (Medicare) paid $48.00 and CHAMPVA paid $6.00. $48.00 + $6.00 = $54.00. The difference between the CHAMPVA allowable and the amount paid by Medicare and CHAMPVA is $4.00, so that is the beneficiary's payment responsibility. The CHAMPVA deductible will be fully credited.

(2.) DRG-based inpatient services covered by Medicare and CHAMPVA. Effective for claims processed on or after January 1, 1999, there is a four-step method to determine the CHAMPVA payment when Medicare is the primary payer. [NOTE: the effective date relates to the date of processing, not to the date of service.] In most cases, this allows CHAMPVA to cover the beneficiary's Medicare inpatient deductible.

STEP	ACTION
1	Determine the DRG-based amount CHAMPVA will allow minus the beneficiary's cost share.
2	Subtract the OHI payment from the billed charge.
3	Subtract the cost share from the billed charge.
4	Compare the amounts in steps 1 through 3 and pay the lowest.

An example of this payment computation is outlined as follows: A provider bills $5,401.04 for a 4-day inpatient stay. The claim is subject to the DRG-based system and the DRG amount is $3740.44. The cost share is $1350.26. Medicare paid $4589.04. The provider submitted the claim for the balance of $812.00 along with Medicare's explanation of benefits (EOB).

Step 1 $3,740.44 (CHAMPVA allowable amount)
-1,350. 26 (Cost share)
$2,390.18

Step 2 $5,401.04 (Billed amount)
- 4,589.04 (OHI payment)
$ 812.00

Step 3 $5,401.04 (Billed amount)
- 1,350.26 (Cost share)
$4,050.78

Step 4 Compare Steps 1, 2, and 3 and pay the lesser. In this case, CHAMPVA will pay Step 2 or $812.00. The claim has been paid in full with no out-of-pocket expense to the beneficiary.

F. CHAMPVA and Medicaid. Medicaid is essentially a welfare program, providing medical benefits for persons under various state welfare programs. In accordance with Public Law 97-377, it was the intent of Congress that no authorized beneficiary should have to resort to welfare programs; therefore, Medicaid was exempted from the double coverage provisions. Whenever a CHAMPVA beneficiary is also eligible for Medicaid, CHAMPVA becomes the primary payer. In those instances where Medicaid extends benefits on behalf of a Medicaid eligible person who is subsequently determined to be a CHAMPVA beneficiary, CHAMPVA will reimburse the appropriate Medicaid agency for the amount CHAMPVA would have paid in the absence of Medicaid benefits or the amount paid by Medicaid, whichever is less.

G. CHAMPVA and State Victims of Crime Compensation Programs. CHAMPVA is always the primary payer for beneficiaries who are also eligible under a State Victims of Crime Compensation Program.

H. CHAMPVA and Workers' Compensation. CHAMPVA benefits are specifically excluded for any medical service and supply provided to a beneficiary to treat a work-related illness or injury for which benefits are available under a workers' compensation program. It is the beneficiary's responsibility to apply for workers' compensation benefits. To recover benefits for a work-related illness or injury, a beneficiary must pursue his/her rights under the Workers' Compensation Act or any of the above provisions that may apply to the illness or injury. This includes filing an appeal with the Industrial Commission, if necessary. Workers' Compensation applies to illness or injury resulting from occupational accidents or sickness covered under occupational disease laws; employer's liability laws; Federal, Sate, or municipal law; and the Workers' Compensation Act.

1. When a legitimate dispute exists as to whether an injury or illness is work-related, CHAMPVA will provide benefits during the appeal process.

2. Recoupment action will be taken as appropriate in instances where CHAMPVA assumed the role as primary payer when workers' compensation is involved.

3. If a beneficiary exhausts available workers' compensation benefits, CHAMPVA will assume benefits for otherwise covered services and supplies.

4. CHAMPVA benefits will not be extended for work-related illness or injury when the beneficiary fails to file a claim with Workers' Compensation within the filing period allowed by law or the beneficiary obtains care for the work-related injury or illness that is not authorized by Worker's Compensation and is not a covered benefit under CHAMPVA

I. CHAMPVA and Third Party Insurance. CHAMPVA will be secondary payer in all instances where there is third party liability. For example, a beneficiary who is involved in an automobile accident is required to file their medical claim with their (or responsible party's) automobile insurance before submitting it to HAC. Upon receiving the EOB statement from the automobile insurance company, a claimant may file a CHAMPVA claim for any remaining balance.

1. If necessary to ensure the medical needs of the beneficiary are met, CHAMPVA will provide payment for medically required services until a determination has been made regarding third party liability.

2. Recoupment action will be taken as appropriate in instances where CHAMPVA has assumed the role as primary payer where third party insurance is involved.

3. A claim that reflects OHI involvement will be processed under the same payment methodology as previously described.

J. Claims processed under the CHAMPVA DRG-based payment system or the inpatient mental health per diem payment system. When OHI exists and the DRG-

based amount or the per diem amount is greater than the hospital's actual billed charge, and the primary payer has paid the full-billed charge, no additional payment will be made by CHAMPVA. When the DRG-based amount or the per diem based amount is less than the hospital's actual billed charge, and the primary payer has paid the full DRG-based amount or the per diem based amount, no additional payment can be made. By law, the hospital cannot bill the beneficiary for any additional amounts.

IV. POLICY CONSIDERATIONS

A. All double coverage claims should be accompanied by an explanation of benefits (EOB) from the primary insurer.

B. Surrogate arrangements. A contractual arrangement between the surrogate mother and the adoptive parents is considered other health coverage. As such, the claims will be processed under the three-step methodology. CHAMPVA will cost share the remaining balance of covered benefits related to the surrogate mother's medical expenses after the contractually agreed upon amount has been exhausted. This is applicable regardless if the contractual arrangement requires for the adoptive parents to pay all or part of the medical expenses. When the contractual arrangement does not specifically address reimbursement for the surrogate mother's medical care, the claim will be processed under the DRG payment methodology.

V. EXCLUSIONS

A. CHAMPVA supplemental insurance plans that, for all categories of beneficiaries, provide solely for cash payment of deductibles, cost shares, and amounts for non-covered services due to program limitations or for which the enrollee is liable.

B. Income maintenance programs that provide cash payments for periods of hospitalization or disability, regardless of the amount or type of services required or the expenses incurred. These plans are not intended to actually pay for medical services, but are intended only to supplement the beneficiary's income during a time of increased expenses and/or lowered income. On the other hand, a plan that varies its benefits, depending upon the care received or the patient's diagnosis, is considered to be health insurance coverage as opposed to an income supplement, and would be primary payer to CHAMPVA. Any payment made directly to the provider of care, as opposed to the beneficiary, can be assumed to be an insurance plan and not an income supplement.

C. Certain federal government programs that are designed to provide benefits to a distinct beneficiary population and for which entitlement does not derive from either premium payment or monetary contribution (e.g., Medicaid and Workers' Compensation).

D. Health care delivery systems not considered within the definition of an insurance plan, medical service or health plan include the State Victims of Crime Compensation Programs, Maternal and Child Health Program, or the Indian Health Services. Programs such as these are designed to provide benefits to a distinct beneficiary population, and they require no premium payment or monetary contribution prior to obtaining care.

END OF POLICY